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If you have any comments on this draft form, you can submit them to us on our web site. Include the word DRAFT in your response. You may make comments anonymously, or you may include your name and e-mail address or phone number. We will be unable to respond to all comments due to the high volume we receive. However, we will carefully consider each suggestion. So that we can properly consider your comments, please send them to us within 30 days from the date the draft was posted.

ISSUER'S name, street address, city, state, ZIP code, and telephone no.		<div>OMB No. 1545-xxxx</div> <div>2002</div> <div>Form 8887</div>	<div>Health Insurance Credit Eligibility Certificate</div>
ISSUER'S Federal identification number	RECIPIENT'S identification number		
RECIPIENT'S name Street address (including apt. no.) City, state, and ZIP code		Recipient is an eligible: <input type="checkbox"/> TAA or alternative TAA recipient <input type="checkbox"/> PBGC pension recipient	<div>Copy A</div> <div>For Recipient</div> <div>(keep for your records)</div> <div>You may be able to claim the health insurance credit for eligible recipients. See Form 8885 for details.</div>
For optional use by issuer			

Form **8887** (2002)

Cat. No. 34756D

Department of the Treasury - Internal Revenue Service

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